FOR IMMEDIATE RELEASE

Egyptian Regional Human Rights Authority
Report of Findings
11-110-9051
Chester Mental Health Center
November 8, 2011

The Egyptian Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation concerning Chester Mental Health Center, a state-operated mental health facility located in Chester. The specific allegations are as follows:

1. A recipient at Chester Mental Health Center has been inappropriately restricted from making telephone calls to persons of his choice.
2. A recipient at the facility has not been provided with adequate care and services.

Statutes

If substantiated, the allegations would be violations of the Mental Health and Developmental Disabilities Code (Code) (405 ILCS 5/2-103, 5/2-201, 5/2-102 and 5/1-101.2)

Section 5/2-103 of the Code states," Except as provided in this Section, a recipient who resides in a mental health or developmental disabilities facility shall be permitted unimpeded, private, and uncensored communication with persons of his choice by mail, telephone and visitation, (a) The facility director shall ensure that correspondence can be conveniently received and mailed, that telephones are reasonably accessible, and that space for visits is available. Writing materials, postage and telephone usage funds shall be provided in reasonable amounts to recipients who reside in department facilities and who are unable to procure such items. (b) Reasonable times and places for the use of telephones and for visits may be established in writing by the facility director. (c) Unimpeded, private and uncensored communication by mail, telephone, and visitation may be reasonable restricted by the facility director only in order to protect the recipient or others from harm, harassment or intimidation, provided that notice of such restriction shall be given to all recipients upon admission. When communications are restricted, the facility shall advise the recipient that he has the right to require the facility to notify the affected parties of the restriction, and to notify such affected parties of when the restrictions are no longer in effect. However, all letters addressed by a recipient to the Governor, members of the General Assembly, Attorney General, judges, states attorneys, Guardianship and Advocacy Commission, or the Agency designated pursuant to 'An Act in relation to the protection and advocacy of the rights of persons with developmental disabilities, and amending Acts therein named', approved September 20, 1985, officers of the Department, or licensed attorneys at law must be forwarded at once to the persons to whom they are addressed without

examination by the facility authorities. Letters in reply from the officials and attorneys mentioned above must be delivered to the recipient without examination by the facility authorities..."

Section 2-201 states, " (a) Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction or use or restraint or seclusion and the reason therefor to: (1) the recipient and, if such recipient is a minor or under guardianship, his parent or guardian; (2) a person designated under subsection (b) of Section 2-200 upon commencement of services or any later time to receive such notice: (3) the facility director; (4) the Guardianship and Advocacy Commission, or the agency designated under 'An Act in relation to the protection and advocacy of the rights of persons with developmental disabilities, and amending Acts therein named;, approved September 20, 1985, if either is so designated; and (5) the recipient's substitute decision maker, if any. The professional shall also be responsible for promptly recording such restriction or use of restraint or seclusion and the reason therefor in the recipient's record. (b) The facility director shall maintain a file of all notices of restrictions of rights, or the use of restraint or seclusion for the past 3 years. The facility director shall allow the Guardianship and Advocacy Commission, the agency designated by the Governor under Section 1 of 'An Act in relation to the protection and advocacy of the rights of persons with developmental disabilities, and amending Acts therein named',: approved September 30, 1985, and the Department to examine and copy such records upon request. Records obtained under this Section shall not be further disclosed except pursuant to written authorization of the recipient under Section 5 of the Mental Health and Developmental Disabilities Confidentiality Act."

Section 5/2-102 states, "A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment plan. In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided. The recipient's preference regarding emergency intervention under Subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan."

Section 5/1-101.2 states, "'Adequate and humane care and services' means services reasonably calculated to result in a significant improvement of the condition of a recipient of services confined in an inpatient mental health facility so that he or she may be released or services reasonably calculated to prevent further decline in the clinical condition of a recipient of services so that he or she does not present an imminent danger to self of others."

Investigation Information for Allegation 1

Allegation 1: A recipient at Chester Mental Health Center has been inappropriately restricted from making telephone calls to persons of his choice. To investigate the allegation, the HRA Investigation Team conducted two site visits at the facility. During the initial visit, the Team, consisting of two members and the HRA Coordinator (Coordinator), spoke with the recipient whose rights were alleged to have been violated and the Chairman (Chairman) of the facility's Human Rights Committee. With the recipient's written authorization, copies of information pertinent to the allegation were requested in order that the Authority might review the information. During the second visit, the Team, consisting of a member, the HRA Director (Director) and the Coordinator spoke with the Chairman. Facility policy pertinent to the allegation was also reviewed.

A...Interviews:

1)...Recipient:

The recipient informed the Team that he was admitted to the facility on 01/24/11 from a northern Illinois county jail as Unfit to Stand Trial (UST). He stated that he did not believe that he needed to be hospitalized in the most restrictive facility in the state. The recipient related that since he had been at the facility his right to communicate with individuals of his choice had been restricted. He informed the Team that staff will not allow him to call his wife or a female friend.

2):...Chairman

During the initial visit, the Chairman stated that it is the facility's policy to encourage communication between recipients and others outside the facility. He stated that the phones, which are located on the module, are activated for recipients' use according to the facility's phone schedule. The schedule allows four one hour daily periods for each unit in order that all recipients might be able to maintain communication with family and others outside of the facility. The Chairman related that a communication is only restricted when it is necessary to prevent harm or harassment to a recipient or to prevent the recipient from causing harm or harassment to others.

During the second visit, the Chairman stated that whenever it is necessary to restrict a recipient's communication by telephone, the recipient is provided with a Restriction of Rights Notice (Notice) pertinent to the restriction, and a copy of the Notice is placed in the recipient's clinical chart.

B...Clinical Chart Review:

1)...Treatment Plan Reviews (TPRs)

According to the recipient's 04/05/11 TPR, he was admitted to the facility on 01/24/11 after being adjudicated UST on 11/05/10 on the charge of Violation of an Order of Protection and Trespassing. He was recommended for placement at Chester Mental Health Center because he was hostile, easily provoked by peers, and uncooperative with staff, daily routines, and

interviews. Documentation indicated that at the time of admission, the recipient had a difficult time focusing on the subject matter.

The recipient's problem areas were listed as follows: 1) UST, 2) Psychotic symptoms and 3) Aggression. His strengths were listed as: 1) Able to perform Activities of Daily Living (ADLs) independently, 2) Has held gainful employments and 3) Is a high school graduate.

The recipient's diagnoses were listed as follows: AXIS I: Schizophrenia Paranoid; AXIS II: Defer-R/O (Rule Out) Schizoid Schizotypical Personality Disorder; 3) AXIS III: Asthma, Allergic to Penicillin; and AXIS IV: Chronic Institutionalization.

Documentation in the 04/05/11 TPR indicated that the recipient had refused to take psychotropic medication. The record indicated that he does not believe that he has a mental illness, despite eighteen prior hospital admissions to psychiatric facilities.

Goals to address each problem area were incorporated in the recipient's TPR. A goal to restore to a level of fitness to stand trial by 06/25/11 was listed to address the recipient's UST status. Objectives to reach the goal were listed as follows; 1) take prescribed medication; 2) cooperate with an evaluation of fitness, 3) participate in fitness education, and 4) demonstrate the ability to cooperate with the treatment regimen and unit rules and routines by attending at least three activity programs or leisure opportunities per week. An additional goal for the recipient to be free of displaying aggressive behavior toward others was incorporated in the TPR. Objectives listed to reaching the goal were as follows: 1) Follow unit rules and routine: 2) Have no instances of verbal aggression, physical aggression and property destruction; and 3) Reinforce appropriate social behaviors by offering a behavior support program with a clear and a consistent reward system. To address the problem of psychotic symptoms, objectives listed were: 1) Cooperate with a mental status evaluation; 2) Express intent to take medication; 3) Nursing and STA staff will monitor the patient's statements and actions related to psychosis, provide reality orientation and avoid undue attention to the psychotic content; and 4) The recipient's therapist will monitor his mental status in therapy sessions.

Additional documentation in the 04/05/11 TPR indicated that the recipient had not requested to speak or contact any family member or significant others and had indicated that he was estranged from his family.

Documentation in the recipient's 05/04/11 TPR indicated that a recipient's family member (Family Member 1) had called the facility to make the recipient aware of how another family member (Family Member II) was doing. The record indicated that the Family Member I stated that the recipient had not contacted his family; however; they would continue to write him and were concerned about his progress.

According to additional recordings in the 05/04/11 TPR, staff members observed the recipient becoming agitated and heard his verbal aggression with someone that he was speaking to on the telephone. Upon hearing the verbally aggression, the staff member attempted to calm the recipient but found it difficult to redirect him.

2)...Progress Notes

A Social Worker documented in a 04/04/11 Progress Note that she had attempted to speak with the recipient about his actions which resulted in the breakage of the patients' telephone. According to the Social Worker's documentation, the recipient stated that three other recipients prevented him from using the telephone, and the STAs in the area did nothing to address the situation. When the Social Worker asked the recipient is he had reacted in an intimidating and physically aggressive action toward the STAs, he stated that he had and would take his frustrations out on everyone because all of the staff members were trying to "keep him from his girl."

Documentation in a 06/03/11 Social Worker's Progress Note indicated that Family Member I had contacted the facility to ask about what the family could send to the recipient. According to the documentation, Family Member I stated that the recipient had requested that she send "Pepsi Cola, granola bars, clothing and trail mix." The Social Worker recorded that she informed the family member that caffeinated sodas were not allowed, and approved soft drinks could be purchased at the facility commissary. According to the Social Worker's documentation, Family Member I stated that the family would send him a package containing the other requested items.

Additional documentation indicated that Family Member I had sent a letter to the facility stating that the recipient had been calling Family Member II threatening to kill her when he was released. According to Family Member I, the threatening calls to Family Member II had occurred almost daily and were hindering Family Member II's recovery from surgery. Family Member I requested that the facility restricted the recipient from making the threatening calls to Family Member II. The letter was received at the facility on 06/30/11.

3)... Restriction Notice:

A Restriction of Rights Notice (Notice) was issued at 10:30 AM on 07/01/11 prohibiting the recipient from communication via telephone with Family Member II. The reason listed was the recipient had made threats of physical harm toward Family Member II, and upon request by the family, the restriction was issued. Documentation indicated that the Notice was given to the recipient in English and he stated that he did not wish to have anyone notified of the restriction. Documentation indicated that the Restriction was issued for a period of 07/01/11 to 08/01/11, and was signed by the facility Director. The Authority did not observe any other Notices relevant to restriction of the recipient's right to communicate with anyone other than Family Member II.

C: Patient Telephone Calls Policy:

According to the Policy Statement, "It shall be the policy of Chester Mental Health Center to foster communication between patients and others outside the facility via telephone calls."

In the Outgoing Section of the Policy, documentation indicated that recipients are allowed two free calls upon admission. The admitting nurse will inform the recipient that he

may place two telephone calls at facility expense when he arrives at the assigned unit. The recipient will be permitted to place the two telephone calls to parties of his choosing if his condition permits. The call should be kept at a reasonable length and should be made on the module phone or in a therapist's office. If the recipient's condition upon admission precludes his ability to make the calls or the patient refuses the offer, that information is to be recorded in the Unit Telephone Log, as well as, in a Progress Notes in the recipient's clinical chart. The recipient's acceptance to make the calls will also be recorded in the Telephone Log

Documentation in the Policy indicated that recipients are encouraged to maintain contact with family or others outside of the facility on an on-going basis. The location of the module recipient phone, phone schedule (4 one hour periods daily), and the procedures for placing collect, toll-free and calling card calls are listed in the Policy.

The Policy addressed duration of the recipients' calls. Documentation indicated that if there is another recipient waiting to make a call, each phone call should be limited to a 10-minute period. However, if there is no one else waiting, there is no time limit during designated calling periods. If an emergency situation arises during the course of a recipient's call, he may be asked to curtain his call and re-initiate another call once the emergency situation is over.

The Policy allows STA staff to maintain visual contact during telephone use to ensure that the communication occurs without intrusion from others. Additionally, the Policy allows for arranging for non-routine calls at the facility's expense in special situations, such as emergencies, lack of recipient funds, therapist approved calls, etc. In such situation, the recipient's unit director, unit manager, therapist or facility administrator will give approval for the call.

The Policy states, "A patient may have his telephone use restricted by the hospital administrator to protect him or others from harm, harassment or intimidation. If a restriction is imposed, the treatment team is to provide notice of such restriction using form MHDD-4, Notice of Patients Restriction, Rev. 3/91, in accordance with the process described in Section 2-201 of the Mental Health and Developmental Disabilities Code."

The Policy outlines the procedure for handling incoming call for recipients. Calls received by the switchboard for recipients are to be routed to the shift supervisor. Upon receipt, the shift supervisor, while not acknowledging that a recipient resides at the facility, will inquire as to whether or not an emergency exists. The supervisor will make note of the names and telephone numbers of the persons making the call while informing the party that the patient, if at the facility, will be given the opportunity to return the call. The recipient will be notified as soon as possible of the call and given the opportunity to return the call. The procedure is to ensure that recipients' rights to confidentiality are protected.

The Policy also provides procedures for handling calls inquiring about recipients. Without authorization for release of information from the recipient, no information will be released.

Summary for Allegation 1

According to the recipient whose rights were alleged to have been violated, staff members at the facility had restricted him from calling his wife and a friend. Documentation in the recipient's clinical chart indicated that the recipient was restricted from calling a family member; however, the family member was not listed as his wife. The record indicated the restriction was implemented due to the recipient making threatening, harassing calls to the family member, and the restriction was executed at the family member's request. Documentation indicated that the recipient was provided with a Restriction of Rights Notice for a period of thirty days with review at the end of the period. The facility has a relevant Policy entitled, "Patient Telephone Call Policy", which is in accordance with the Mental Health and Developmental Disabilities Code, as well as, the Mental Health and Developmental Confidentiality Act.

Conclusion of Allegation 1

Based on the information that the recipient had made threatening, harassing calls to a family member, a rights violation did not occur when the facility restricted the recipient from making calling to a family member. Therefore, the allegation that the recipient was inappropriately restricted from making telephone calls to a person of his choice is unsubstantiated. No recommendations are issued

Investigation of Allegation 2

Allegation 2: A recipient at the facility has not been provided with adequate care and services. To investigate the allegation, the Team conducted two site visits at the facility. During the initial visit, the Team spoke with the recipient whose rights were alleged to have been violated and the Chairman. During the second visit, the Team spoke with the Chairman. With the recipient's written authorization, copies of information from his clinical chart were obtained, and the Authority reviewed the information. Facility policies pertinent to the allegation were also reviewed.

A...Interviews:

1)..Recipient:

The recipient informed the Team that he has lost a considerable amount of weight; however, facility staff members have not attempted to determine the cause of the weight loss. The recipient also voiced concerns regarding the lack of staff involvement with recipient-on-recipient aggression. He stated that he had been injured by other recipients on several occasions. The recipient informed the Team that he did not believe that he has received adequate care since his January 2011 admission to the facility.

2)...Chairman:

The Chairman stated that recipients are weighed upon admission and monthly thereafter. The Chairman reported that in the event a recipient experiences a significant weight loss or gain, a referral is made to the facility dietician.

The Chairman stated that for a period of time the recipient was experiencing psychotic symptoms, refusing medication, periodically declining to eat meals and exhibiting aggressive actions toward others. According to the Chairman, the recipient's condition has improved since he has been receiving court-ordered medication.

The Chairman stated that the facility has policies related to monitoring a recipient's weight and diet appropriateness.

B...Clinical Chart Review:

1)...TPRs

Documentation in a 04/05/11 TPR indicated that the recipient was involved in a physical altercation with a peer on 02/25/11; however, restraint application was not necessary. Additional recordings indicated that it had been necessary for staff to redirect the recipient on several occasions due to his loud, agitated behaviors when talking on the telephone and his "cursing, ranting and raving at peers" within the facility.

Recordings in a 05/04/11 TPR indicated that the recipient continued to have problems with redirection when he was requested to cease his loud, agitated behaviors. Documentation in a 06/01/11 TPR indicated that the recipient had little or no insight into his problems. However, he had been more compliant since court ordered medication was implemented on 05/23/11.

The Authority did not observe any documentation in the TPRs to indicate a concern regarding the recipient's weight loss or health issues which might be associated with the weight loss.

2)...Progress Notes:

Documentation in a 04/04/11 Registered Nurse's (RN) Progress Note completed at 12:55 PM indicated that the recipient stated that an area on his lower left leg hurt because another recipient pushed the couch into his leg. The RN recorded that no swelling, redness or open area were noted. He was given an ice bag and a facility physician was notified. The record indicated that when the physician examined the recipient no acute findings were identified.

In an additional 04/04/11 Progress Note at 7 PM, an RN recorded that the recipient alleged that he was struck in the left eye by a peer. The RN documented that the recipient was examined, neurological checks conducted, an ice bag applied and an injury report completed.

On 04/04/11, a facility physician recorded in 10 PM Medical Progress Note that he had examined the recipient after he alleged being hit in the left eye by a peer. The physician recorded that the examination did not reveal any injuries.

A Security Therapy Aide (STA) recorded in a 04/12/11 Progress Note that the recipient had been asked to end his phone call so that he could get into line for an evening meal. The STA documented that the recipient became very hostile toward staff and refused to go to the meal. The STA recorded that when a tray was brought back to him on the unit, he refused to accept the meal.

A Registered Dietician (Dietician) recorded in a 04/18/11 Progress Note that upon admission the recipient was receiving a low fat diet due to a history of dyslipidemia, and the diet would be continued. Additional documentation indicated that the recipient had a good appetite, and his current weight was 152 lbs, which was within an Ideal Body Weight (IBW) of 139-169. His height was listed as 68 inches. The Dietician recorded that the recipient was receiving medication for lipid control. All labs conducted on 01/26/11 were recorded to be within normal limits.

An STA recorded in a 05/03/11 Progress Note that the recipient stated that he did not want his breakfast tray. When the STA asked him the second time if he wanted to eat, he refused once more. Documentation in a 05/20/11 STAs Progress Note indicated that the recipient was asked three times if he wanted a tray for the evening meal; however, he refused all offers.

Documentation in a 05/20/11 Progress Note recorded at 6:15 PM indicated that the recipient attempted to attack staff and barricade himself in his room. An STA recorded that the recipient was placed in four-point restraints for the safety of all.

Documentation indicated that the recipient refused this evening meal on 05/21/11. An RN recorded that staff encouraged the recipient and made three attempts to get him to eat. However, he continued to refuse and state, "I don't want that crap."

After interviewing the recipient on 5/24/11, a facility Psychiatrist recorded that the recipient's condition had gradually decompensated, and he was paranoid and out of touch with reality. The Psychiatrist documented that numerous Behavior Data Reports had been issued due to the recipient's aggressive behaviors, and he had required restraints after he attempted to attack staff and his peers. The psychiatrist recommended that enforced court-ordered psychotropic medication be sought. Documentation in a 06/01/11 Psychiatrist Progress Note indicated that a court hearing had been conducted and approval for the involuntary administration of psychotropic medication had been obtained.

Documentation in a 06/03/11 Progress Note completed by a Social Worker indicated that a Release of Information Form was signed by the recipient authorizing information to be provided to a gastroenterologist in order that the recipient could obtain treatment.

Documentation in a 06/08/11 RN's Progress Note indicated that when the recipient was struck by another peer, his head hit on the wall causing some edema. The RN recorded that according to the recipient and staff who were working with the recipient there were no changes in the recipient's level of consciousness. The RN recorded that a facility physician ordered

Ibuprofen be administered, a cold pack applied to the scalp and a x-ray completed. The recipient's vital signs were taken and the x-ray was completed.

A Dietician recorded in a 06/09/11 Progress Note that the recipient diet was changed to a regular diet from a heart health diet. The Dietician documented that an additional 300 to 500 calories per day had been added to the diet due to the recipient's weight loss. His weight was recorded as 132 lbs on 06/11/11, a decrease of 23 lbs within 13 months.

An RN recorded in a 06/29/11 Progress Note that when the recipient returned from the recreation yard, he reported that a bee had stung him behind his ear, and when he hit the bee with his hand, he hit his arm at the site of a previous injury. The RN recorded that a he had a pinpoint red dot behind his right ear and swelling on his right inner forearm; however, no redness, swelling or open area where the previous injury had occurred. Documentation indicated that the recipient was examined by the facility physician. No major concerns were noted.

<u>3)... Nursing Assessments:</u>

Documentation in an Initial Nursing Assessment completed on 01/25/11, the day after the recipient's admission, listed the recipient weight as 156 lbs. The Initial Nutritional Screening listed the recipient's weights as 156 lbs and height as 68 inches. His ideal Body weight Range was listed as 139-169. Screening information indicated that the recipient had not experienced a weight loss or gain of 5% or more within the past 30 days or a weight loss or gain of 10% or more during the last 180 days. Additional documentation indicated there was not a history or any reports by the recipient of malnutrition or other nutritionally related diagnoses. The record indicated that the recipient did not express a need or desire for any type of special dietary considerations. The recipient's diet was listed as low fat.

The recipient's weight was recorded as 158 lbs in a Nursing Reassessment Summary completed on 02/06/11. Documentation indicated that the recipient had expressed no physical complaints or injuries. No dental vision or outside consultations had been conducted for the reporting period. The record indicated that the recipient had a history of peptic ulcer disease, facial acne, hyperlipidemia, and GERD (Gastroesophageal Reflux Disease). The recipient's appetite was listed as good , and the record indicated that he had gained 2 lbs since admission.

Documentation in a Nursing Reassessment Summary on 02/14/11 for the period 02/08/11 to 02/14/11 indicated that the recipient's weight remained the same (158 lbs), his appetite was good, and he remained on a low fat diet.

According to a Nursing Reassessment Summary completed on 02/21/11, the recipient's weight remained 158 lbs, and he continued to have a good appetite. He had not sustained any injuries or had any physical complaints. No outside consultation had been conducted. The record indicated that the recipient was receiving Simvastatin for elevated lipids and a topical solution for acne. Additional documentation indicated that the recipient has delusions, some behavior problems on the unit and had refused psychotropic medication(s).

A Nursing Reassessment Summary for the period 02/22/11 to 03/06/11 indicated that the recipient's weight remained at 158 lbs. He had complained of an injury that he received during a volleyball game, as well as many minor medical complaints. He was examined by a facility physician; however, no outside consultations had been conducted. His appetite was recorded as good. No diet changes had been implemented during the reporting period.

Documentation in a Nursing Reassessment Summary for the Period of 03/07/11 to 04/03/11 indicated that the recipient had complained about receiving an injury to his forearm and elbow due to repeatedly serving while playing volleyball. The record indicated that when he was examined by a facility physician, no apparent injuries were revealed. Additional documentation revealed that the recipient was involved in two minor physical altercations with peers which resulted in very minor injuries. No outside consultations were ordered during the reporting period. The recipient's weight was recorded as 155 lbs, which is within his IBW. According to the record the recipient continued to be on a low fat diet, and received medication to lower cholesterol (Sinvastatin) and medication for GERD (Omeprazole).

Documentation in a Nursing Reassessment Summary for the period 04/04/11 to 05/01/11 indicated that the recipient had lost 3 lbs; however, he remained within his IBW and his appetite was good. The record indicated that he continued to be on a low fat diet. Additional documentation revealed that the recipient had complained of injury to his right leg after a peer pushed him into the couch. He also complained of obtained an injury to his left eye after he was struck by a peer. Upon examination, the injuries were listed as minor.

According to recordings in a Nursing Reassessment Summary for the period of 05/02/11 to 05/29/11, the recipient had lost 12 lb.; however he remained within his IBW (139-169). His weight was listed as 140 lbs. Documentation indicated that he remained on a low fat diet. Additional recordings revealed that the recipient had complained of a minor injury due to the accidental bumping of his head on a door in his room. The record indicated that the recipient had also complained of lower back and arm pain. X-rays were completed on 05/04/11. No other exams or outside consultations were recorded for the reporting period.

Documentation in a Nursing Reassessment Summary for the period 05/30/11 to 6/22/11 indicated that the recipient had lost 8 lbs during the reporting period. His weight was listed as 132 lbs, 7 lbs below his IBW. The recipient's appetite was listed as fair. He was referred for nutritional assessment, and his diet was changed from low fat to regular diet with increased calories. The record indicated that the recipient was stuck on his head by a peer. The recipient was examined and an x-ray completed. According to documentation, the recipient chronically complains about multiple injuries, usually caused by sports activities. However, little, if any injury is present when he is examined. The record indicated that his pre-occupation with imagined injuries has shown little improvement. Additional documentation indicated that the recipient was placed on court ordered medication on 06/01/11, and his maladaptive behaviors and mania had shown some improvements since the implementation.

According to a Nursing Reassessment Summary for the period of 06/23/11 to 07/18/11, the recipient had gained 5 lbs since the last assessment was completed. The recipient's diet was listed as regular with increased calories, and his appetite was listed as fair. The record indicated

that the recipient continued to have numerous physical complaints including being stung by a bee and experiencing shoulder pain, pain in the forearm and headaches. The record indicated that the recipient was admitted to the infirmary for one day due to possible dehydration.

4)...Vital Signs and Weight Records Form (Form)

Documentation indicated that the recipient's blood pressure, temperature, pulse rate, respiration rate, height and weight were recorded on the Form. The recipient's weights were recorded as follows:

Date	Weight
01/25/11	156
02/06/11	158
03/08/11	155
04/07/11	152
05/03/11	140
06/07/11	132
06/26/11	137
08/08/11	150
08/28/11	155
09/29/11	164

5)...Laboratory and Diagnostic Procedures:

Documentation indicated that that on 06/02/11, a Liver Profile, Lipids. Triglycerides, HDL and LDL tests were conducted. All findings were within the normal limits. On 08/11/11, glucose testing was conducted. On 09/22/11, a Complete Blood Count (CBC) and Comprehensive Metabolic Panel (CMP) were completed. All findings were within the normal range.

6)...Injury Reports:

Date	Description of Injury	Physician's Examination
01/26/11	Confrontation with another individual prior to admission Struck in flank.	No clinical sign of any trauma
02/24/11	Alleges muscle pull in right thing and broken right thumb while playing volley ball.	Able to walk normally, range of motion normal. Grip equal and strong. No redness. No treatment

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		required.
02/25/11	Alleges being kicked in the ribs and hip by another recipient.	No bruising, skin slightly red, breathing normal_ Contusion on left flank. Minor first aid given
03/13/11	Complained of pain in left forearm and elbow from playing volleyball.	No noted tenderness, swelling, or redness in forearm, normal range of motion in joints, radial pulse and neurovascular exam intact. No apparent injury
03/19/11	Alleges being attack by another recipient.	Slight redness on nose and neck No bruising. Minor first aid applied.
04/04/11	Alleges being pushed onto a couch by another recipient. Complained of pain in calf and ankle.	No swelling, redness, warmth to touch. Normal range of motion. Minor first aid completed.
04/04/11	Alleges being hit in eye by another recipient.	Exam failed to reveal any injury after examination and no problem when neuro-checks completed. Ice pack applied.
05/20/11	Accidently hit his head on the doorway.	Offered Ice by RN...Refused Also refused to been examined by physician.
05/26/11	Alleges injury to left arm while playing basketball.	No swelling, redness, or tenderness. Minor first aid applied.
06/08/11	Believed that he was hit in head by another recipient.	No loss of consciousness, some tenderness. Cold pack applied.
06/29/11	Alleges being stung by a bee on his left ear and right arm.	No clinically significant injury noted. Minor first aid applied.
07/03/11	Alleges unknown assailant hit him.	Scratch marks noted on posterior of neck, scratch marks on back and extremities. No swelling or skin discoloration. Range of motion within normal limits. No difficulties

with ambulation. Minor first aid applied.

7)...Physician's Orders for Diet

The Authority observed Physician Orders dated 02/08/11, 02/22/1103/14/11, 03/22/11 and 04/19/11 prescribing a low fat diet. An Order dated 05/16/11 listed the recipient's diet as a heart health diet. On 06/09/11, an Order for a regular diet with increased calories was issued.

C...Facility Policies:

1)...Monthly Weight Policy (Policy I)

According to the Policy I Statement, "It is the policy of Chester Mental Health Center to keep an accurate record of weight on all patients in order to readily identify those patients with significant weight losses or gains."

The procedures are listed as follows: 1) Unit nursing staff will assess the weight of all patients on a monthly basis. 2) Weights are to be recorded on weight record sheet each month within three working days of the time of the weight. 3) A referral for a nutritional assessment will be made if a recipient has experienced weight loss of five percent or more in the previous one-month period, seven and half percent or more for the previous three-month period, and ten percent or more for the previous six-month period. When a recipient experiences a weight gain of ten percent or more in the previous one month period a referral for a Nutritional Assessment will be made.

2)...Ordering and Serving Modified Diets Policy

According to the Policy II Statement, "At Chester Mental Health Center, the Dietary manager II (Registered Dietitian) shall monitor the planning and serving of all modified diet menus to assure that diets are planned for and served to all patients according to their medical and psychological needs."

Procedures outlined in Policy II include nursing/physician's responsibilities, dietary department responsibilities and menu rationale. The nursing/physician's responsibilities are listed as follows; 1) Physician Orders for all modified/special diets and reviewed at least every 30 days. 2) When the Order is completed the unit nurse will contact the dietary supervisor by phone to inform him/her of the modified/special diet order and will deliver the completed order to the dietary department by the end of the shift. 3) The unit nurse will also contact the commissary to inform them of the order. 4) Any recipient's personal preference request that is not medically warranted must be referred to the recipient's treatment team for consideration and approval prior to a physician ordering the special dietary request.

The Dietary Department Responsibilities Section outlines dietary staff members' responsibilities as follows: 1) Regular diets and modified/special diets are prepared in the kitchen by the cooks and served by the assigned support service worker, 2) Diets orders which are not

found on the modified spreadsheets are added and instructions posted in the serving area. 3) Modified diets trays are identified by color-coded cards with the recipient's name, unit and specific diet printed on the card. 4) Copies of the regular menu with diet spreadsheet are given to the support service worker to follow when serving trays to the recipients. 5) A card for each modified diet is set up on the recipient's tray for those recipients coming to the dining room. In order to assure correct delivery trays with modified diets going to the units a paper tray card including the recipient's name and diet will be used.

The Menu Rationale Section of Policy II provides information and the justification for prescription of the following diets: 1) regular, 2) limited concentrated sweets, 3) meat-free and pork-free; 4) bland; 5) mechanical soft; 6) pureed diet; 7) clear liquid; 8) low fat/heart healthy; 9) and increased calorie.

Summary of Allegation 2

According to the recipient, facility staff had failed to address his significant weight loss, as well as, to provide protection of harm from other recipients. Documentation in the recipient's clinical chart indicated that the recipient's weight was 156 lbs when he was admitted to the facility in January 2011 and remained consistent until May 2011. The recipient's weight was listed as 152 lbs on 04/07/11 and 140 lbs on 05/03/11, a loss of 12 lbs within one month. His weight was recorded as 132 lbs on 06/07/11, the loss of an additional 8 lbs. Documentation indicated that the when he was admitted to the facility he was on a low fat/heart healthy diet due to elevated cholesterol levels, and he remained on the diet until 06/09/11. At that time he was placed on a regular diet with increased calories due to his weight loss. After being placed on the regular diet with increased calories, the recipient gained 5 lbs from 06/07/11 until 06/26/11, 13 lbs from 06/26/11 to 08/08/11, 5 lbs from 08/08/11 to 08/28/11 and 9 lbs from 08/28/11 to 09/29/11. The recipient's weight was listed as 164 lbs on 09/29/11. Documentation in Progress Notes indicated that during the period of weight loss, the recipient had periodically refused to eat his meals, and his mental status had deteriorated. However, the HRA's review of the recipient's TPRs did not observe any documentation to indicate that the Treatment Team had discussed the recipient's weight loss. Recordings in a 06/01/11 Psychiatrist Progress Note indicated that a court hearing had been conducted and approval for the administration of psychotropic medication had been approved by the court. Additional documentation indicated that laboratory testing in June, August and September 2011 included liver profile, lipids, triglycerides, HDL, LDL, CBC and CMP. All findings were within normal range.

The recipient's record indicated that since admission he had reported six incidents of being involved in altercations with other recipients. According to the documentation, after each injury was reported, the recipient was examined by a facility physician and minor first aid was administered. Documentation in the recipient's TPR indicated that the recipient was hostile, easily provoked and aggressive toward peers and staff and contained goals to address the problem. Documentation in a Nursing Reassessment Summary indicated that the recipient had chronically complained about multiple injuries, usually caused by sports activities; however, little if any injuries were found when the recipient was examined. The record indicated that the recipient remained preoccupied with imagined injuries.

Conclusion of Allegation 2:

Section 5/1-101.2 defines adequate care and services as service reasonably calculated to result in the significant improvement in a recipient's condition or services to prevent further decline in a recipient's condition. Based on the information obtained, those standards were met therefore, the allegation that the recipient was not provided with adequate care and services is unsubstantiated. No recommendations are issued.

Suggestions and Comments

However, the Authority issues the following suggestions.

1. Whenever a recipient experiences a significant weight loss, the Treatment Team should be aware of the issue. Documentation in the recipient's TPR should reflect discussion of and measures to address the problem

According to the facility's Monthly Weight Policy, when a recipient experiences a weight loss of five percent or more in the previous one-month period, a referral will be made for a Nutritional Assessment. According to documentation, the referral was not made until the recipient had experienced two months of significant weight loss. Therefore, the following suggestion is offered.

2. Referrals for Nutritional Assessments should be made in a timely manner and in accordance with facility policy.